

AMENDED IN SENATE SEPTEMBER 4, 2015

AMENDED IN SENATE AUGUST 31, 2015

AMENDED IN SENATE JULY 1, 2015

AMENDED IN ASSEMBLY MAY 28, 2015

AMENDED IN ASSEMBLY APRIL 21, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

## **ASSEMBLY BILL**

**No. 858**

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**Introduced by Assembly Member Wood**  
(Coauthor: Senator McGuire)

February 26, 2015

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An act to amend Section 14132.100 of the Welfare and Institutions Code, relating to Medi-Cal.

### LEGISLATIVE COUNSEL’S DIGEST

AB 858, as amended, Wood. Medi-Cal: federally qualified health centers and rural health clinics.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons. Existing law provides that federally qualified health center (FQHC) services and rural health clinic (RHC) services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. “Visit” is defined as a face-to-face encounter between a patient of an FQHC or RHC and specified health care professionals. Existing law allows an

FQHC or RHC to apply for an adjustment to its per-visit rate based on a change in the scope of services it provides.

This bill would also include a marriage and family therapist within those health care professionals covered under the definition of “visit.” The bill would require an FQHC or RHC that currently includes the cost of services of a marriage and family therapist for the purposes of establishing its FQHC or RHC rate to apply to the department for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, would require the FQHC or RHC to bill these services as a separate visit, as specified. The bill would require an FQHC or RHC that does not provide the services of a marriage and family therapist, and later elects to add these services, to process the addition of these services as a change in scope of service.

*This bill would incorporate additional changes to Section 14132.100 of the Welfare and Institutions Code made by this bill and SB 610 to take effect if both bills are enacted and this bill is enacted last.*

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: no.

*The people of the State of California do enact as follows:*

1 SECTION 1. Section 14132.100 of the Welfare and Institutions  
2 Code is amended to read:  
3 14132.100. (a) The federally qualified health center services  
4 described in Section 1396d(a)(2)(C) of Title 42 of the United States  
5 Code are covered benefits.  
6 (b) The rural health clinic services described in Section  
7 1396d(a)(2)(B) of Title 42 of the United States Code are covered  
8 benefits.  
9 (c) Federally qualified health center services and rural health  
10 clinic services shall be reimbursed on a per-visit basis in  
11 accordance with the definition of “visit” set forth in subdivision  
12 (g).  
13 (d) Effective October 1, 2004, and on each October 1, thereafter,  
14 until no longer required by federal law, federally qualified health  
15 center (FQHC) and rural health clinic (RHC) per-visit rates shall  
16 be increased by the Medicare Economic Index applicable to  
17 primary care services in the manner provided for in Section  
18 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to  
19 January 1, 2004, FQHC and RHC per-visit rates shall be adjusted

1 by the Medicare Economic Index in accordance with the  
2 methodology set forth in the state plan in effect on October 1,  
3 2001.

4 (e) (1) An FQHC or RHC may apply for an adjustment to its  
5 per-visit rate based on a change in the scope of services provided  
6 by the FQHC or RHC. Rate changes based on a change in the  
7 scope of services provided by an FQHC or RHC shall be evaluated  
8 in accordance with Medicare reasonable cost principles, as set  
9 forth in Part 413 (commencing with Section 413.1) of Title 42 of  
10 the Code of Federal Regulations, or its successor.

11 (2) Subject to the conditions set forth in subparagraphs (A) to  
12 (D), inclusive, of paragraph (3), a change in scope of service means  
13 any of the following:

14 (A) The addition of a new FQHC or RHC service that is not  
15 incorporated in the baseline prospective payment system (PPS)  
16 rate, or a deletion of an FQHC or RHC service that is incorporated  
17 in the baseline PPS rate.

18 (B) A change in service due to amended regulatory requirements  
19 or rules.

20 (C) A change in service resulting from relocating or remodeling  
21 an FQHC or RHC.

22 (D) A change in types of services due to a change in applicable  
23 technology and medical practice utilized by the center or clinic.

24 (E) An increase in service intensity attributable to changes in  
25 the types of patients served, including, but not limited to,  
26 populations with HIV or AIDS, or other chronic diseases, or  
27 homeless, elderly, migrant, or other special populations.

28 (F) Any changes in any of the services described in subdivision  
29 (a) or (b), or in the provider mix of an FQHC or RHC or one of  
30 its sites.

31 (G) Changes in operating costs attributable to capital  
32 expenditures associated with a modification of the scope of any  
33 of the services described in subdivision (a) or (b), including new  
34 or expanded service facilities, regulatory compliance, or changes  
35 in technology or medical practices at the center or clinic.

36 (H) Indirect medical education adjustments and a direct graduate  
37 medical education payment that reflects the costs of providing  
38 teaching services to interns and residents.

39 (I) Any changes in the scope of a project approved by the federal  
40 Health Resources and Services Administration (HRSA).

1 (3) No change in costs shall, in and of itself, be considered a  
2 scope-of-service change unless all of the following apply:

3 (A) The increase or decrease in cost is attributable to an increase  
4 or decrease in the scope of services defined in subdivisions (a) and  
5 (b), as applicable.

6 (B) The cost is allowable under Medicare reasonable cost  
7 principles set forth in Part 413 (commencing with Section 413) of  
8 Subchapter B of Chapter 4 of Title 42 of the Code of Federal  
9 Regulations, or its successor.

10 (C) The change in the scope of services is a change in the type,  
11 intensity, duration, or amount of services, or any combination  
12 thereof.

13 (D) The net change in the FQHC's or RHC's rate equals or  
14 exceeds 1.75 percent for the affected FQHC or RHC site. For  
15 FQHCs and RHCs that filed consolidated cost reports for multiple  
16 sites to establish the initial prospective payment reimbursement  
17 rate, the 1.75-percent threshold shall be applied to the average  
18 per-visit rate of all sites for the purposes of calculating the cost  
19 associated with a scope-of-service change. "Net change" means  
20 the per-visit rate change attributable to the cumulative effect of all  
21 increases and decreases for a particular fiscal year.

22 (4) An FQHC or RHC may submit requests for scope-of-service  
23 changes once per fiscal year, only within 90 days following the  
24 beginning of the FQHC's or RHC's fiscal year. Any approved  
25 increase or decrease in the provider's rate shall be retroactive to  
26 the beginning of the FQHC's or RHC's fiscal year in which the  
27 request is submitted.

28 (5) An FQHC or RHC shall submit a scope-of-service rate  
29 change request within 90 days of the beginning of any FQHC or  
30 RHC fiscal year occurring after the effective date of this section,  
31 if, during the FQHC's or RHC's prior fiscal year, the FQHC or  
32 RHC experienced a decrease in the scope of services provided that  
33 the FQHC or RHC either knew or should have known would have  
34 resulted in a significantly lower per-visit rate. If an FQHC or RHC  
35 discontinues providing onsite pharmacy or dental services, it shall  
36 submit a scope-of-service rate change request within 90 days of  
37 the beginning of the following fiscal year. The rate change shall  
38 be effective as provided for in paragraph (4). As used in this  
39 paragraph, "significantly lower" means an average per-visit rate  
40 decrease in excess of 2.5 percent.

(6) Notwithstanding paragraph (4), if the approved scope-of-service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope-of-service change, the adjusted reimbursement rate for that scope-of-service change shall be made retroactive to the date the scope-of-service change was initially implemented. Scope-of-service changes under this paragraph shall be required to be submitted within the later of 150 days after the adoption and issuance of the written instructions by the department, or 150 days after the end of the FQHC's or RHC's fiscal year ending in 2003.

(7) All references in this subdivision to "fiscal year" shall be construed to be references to the fiscal year of the individual FQHC or RHC, as the case may be.

(f) (1) An FQHC or RHC may request a supplemental payment if extraordinary circumstances beyond the control of the FQHC or RHC occur after December 31, 2001, and PPS payments are insufficient due to these extraordinary circumstances. Supplemental payments arising from extraordinary circumstances under this subdivision shall be solely and exclusively within the discretion of the department and shall not be subject to subdivision (l). These supplemental payments shall be determined separately from the scope-of-service adjustments described in subdivision (e). Extraordinary circumstances include, but are not limited to, acts of nature, changes in applicable requirements in the Health and Safety Code, changes in applicable licensure requirements, and changes in applicable rules or regulations. Mere inflation of costs alone, absent extraordinary circumstances, shall not be grounds for supplemental payment. If an FQHC's or RHC's PPS rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, then a supplemental payment is not warranted.

(2) The department shall accept requests for supplemental payment at any time throughout the prospective payment rate year.

(3) Requests for supplemental payments shall be submitted in writing to the department and shall set forth the reasons for the request. Each request shall be accompanied by sufficient documentation to enable the department to act upon the request. Documentation shall include the data necessary to demonstrate

1 that the circumstances for which supplemental payment is requested  
2 meet the requirements set forth in this section. Documentation  
3 shall include all of the following:

4 (A) A presentation of data to demonstrate reasons for the  
5 FQHC's or RHC's request for a supplemental payment.

6 (B) Documentation showing the cost implications. The cost  
7 impact shall be material and significant, two hundred thousand  
8 dollars (\$200,000) or 1 percent of a facility's total costs, whichever  
9 is less.

10 (4) A request shall be submitted for each affected year.

11 (5) Amounts granted for supplemental payment requests shall  
12 be paid as lump-sum amounts for those years and not as revised  
13 PPS rates, and shall be repaid by the FQHC or RHC to the extent  
14 that it is not expended for the specified purposes.

15 (6) The department shall notify the provider of the department's  
16 discretionary decision in writing.

17 (g) (1) An FQHC or RHC "visit" means a face-to-face  
18 encounter between an FQHC or RHC patient and a physician,  
19 physician assistant, nurse practitioner, certified nurse-midwife,  
20 clinical psychologist, licensed clinical social worker, or a visiting  
21 nurse. For purposes of this section, "physician" shall be interpreted  
22 in a manner consistent with the Centers for Medicare and Medicaid  
23 Services' Medicare Rural Health Clinic and Federally Qualified  
24 Health Center Manual (Publication 27), or its successor, only to  
25 the extent that it defines the professionals whose services are  
26 reimbursable on a per-visit basis and not as to the types of services  
27 that these professionals may render during these visits and shall  
28 include a medical doctor, osteopath, podiatrist, dentist, optometrist,  
29 and chiropractor. A visit shall also include a face-to-face encounter  
30 between an FQHC or RHC patient and a comprehensive perinatal  
31 practitioner, as defined in Section 51179.7 of Title 22 of the  
32 California Code of Regulations, providing comprehensive perinatal  
33 services, a four-hour day of attendance at an adult day health care  
34 center, and any other provider identified in the state plan's  
35 definition of an FQHC or RHC visit.

36 (2) (A) A visit shall also include a face-to-face encounter  
37 between an FQHC or RHC patient and a dental hygienist, a dental  
38 hygienist in alternative practice, or a marriage and family therapist.

39 (B) Notwithstanding subdivision (e), an FQHC or RHC that  
40 currently includes the cost of the services of a dental hygienist in

1 alternative practice, or a marriage and family therapist, for the  
2 purposes of establishing its FQHC or RHC rate shall apply for an  
3 adjustment to its per-visit rate, and, after the rate adjustment has  
4 been approved by the department, shall bill these services as a  
5 separate visit. However, multiple encounters with dental  
6 professionals or marriage and family therapists that take place on  
7 the same day shall constitute a single visit. The department shall  
8 develop the appropriate forms to determine which FQHC's or  
9 RHC's rates shall be adjusted and to facilitate the calculation of  
10 the adjusted rates. An FQHC's or RHC's application for, or the  
11 department's approval of, a rate adjustment pursuant to this  
12 subparagraph shall not constitute a change in scope of service  
13 within the meaning of subdivision (e). An FQHC or RHC that  
14 applies for an adjustment to its rate pursuant to this subparagraph  
15 may continue to bill for all other FQHC or RHC visits at its existing  
16 per-visit rate, subject to reconciliation, until the rate adjustment  
17 for visits between an FQHC or RHC patient and a dental hygienist,  
18 a dental hygienist in alternative practice, or a marriage and family  
19 therapist has been approved. Any approved increase or decrease  
20 in the provider's rate shall be made within six months after the  
21 date of receipt of the department's rate adjustment forms pursuant  
22 to this subparagraph and shall be retroactive to the beginning of  
23 the fiscal year in which the FQHC or RHC submits the request,  
24 but in no case shall the effective date be earlier than January 1,  
25 2008.

26 (C) An FQHC or RHC that does not provide dental hygienist,  
27 dental hygienist in alternative practice, or marriage and family  
28 therapist services, and later elects to add these services, shall  
29 process the addition of these services as a change in scope of  
30 service pursuant to subdivision (e).

31 (h) If FQHC or RHC services are partially reimbursed by a  
32 third-party payer, such as a managed care entity (as defined in  
33 Section 1396u-2(a)(1)(B) of Title 42 of the United States Code),  
34 the Medicare program, or the Child Health and Disability  
35 Prevention (CHDP) program, the department shall reimburse an  
36 FQHC or RHC for the difference between its per-visit PPS rate  
37 and receipts from other plans or programs on a contract-by-contract  
38 basis and not in the aggregate, and may not include managed care  
39 financial incentive payments that are required by federal law to  
40 be excluded from the calculation.

(i) (1) An entity that first qualifies as an FQHC or RHC in the year 2001 or later, a newly licensed facility at a new location added to an existing FQHC or RHC, and any entity that is an existing FQHC or RHC that is relocated to a new site shall each have its reimbursement rate established in accordance with one of the following methods, as selected by the FQHC or RHC:

(A) The rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or adjacent area with a similar caseload.

(B) In the absence of three comparable FQHCs or RHCs with a similar caseload, the rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or an adjacent service area, or in a reasonably similar geographic area with respect to relevant social, health care, and economic characteristics.

(C) At a new entity's one-time election, the department shall establish a reimbursement rate, calculated on a per-visit basis, that is equal to 100 percent of the projected allowable costs to the FQHC or RHC of furnishing FQHC or RHC services during the first 12 months of operation as an FQHC or RHC. After the first 12-month period, the projected per-visit rate shall be increased by the Medicare Economic Index then in effect. The projected allowable costs for the first 12 months shall be cost settled and the prospective payment reimbursement rate shall be adjusted based on actual and allowable cost per visit.

(D) The department may adopt any further and additional methods of setting reimbursement rates for newly qualified FQHCs or RHCs as are consistent with Section 1396a(bb)(4) of Title 42 of the United States Code.

(2) In order for an FQHC or RHC to establish the comparability of its caseload for purposes of subparagraph (A) or (B) of paragraph (1), the department shall require that the FQHC or RHC submit its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report. FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit to the department a completed report in the format



1 applicable to the prior calendar year. FQHCs or RHCs that have  
2 not previously submitted an annual utilization report shall submit  
3 to the department a completed report in the format applicable to  
4 the prior calendar year. The FQHC or RHC shall not be required  
5 to submit the annual utilization report for the comparable FQHCs  
6 or RHCs to the department, but shall be required to identify the  
7 comparable FQHCs or RHCs.

8 (3) The rate for any newly qualified entity set forth under this  
9 subdivision shall be effective retroactively to the later of the date  
10 that the entity was first qualified by the applicable federal agency  
11 as an FQHC or RHC, the date a new facility at a new location was  
12 added to an existing FQHC or RHC, or the date on which an  
13 existing FQHC or RHC was relocated to a new site. The FQHC  
14 or RHC shall be permitted to continue billing for Medi-Cal covered  
15 benefits on a fee-for-service basis under its existing provider  
16 number until it is informed of its FQHC or RHC enrollment  
17 approval, and the department shall reconcile the difference between  
18 the fee-for-service payments and the FQHC's or RHC's prospective  
19 payment rate at that time.

20 (j) Visits occurring at an intermittent clinic site, as defined in  
21 subdivision (h) of Section 1206 of the Health and Safety Code, of  
22 an existing FQHC or RHC, or in a mobile unit as defined by  
23 paragraph (2) of subdivision (b) of Section 1765.105 of the Health  
24 and Safety Code, shall be billed by and reimbursed at the same  
25 rate as the FQHC or RHC establishing the intermittent clinic site  
26 or the mobile unit, subject to the right of the FQHC or RHC to  
27 request a scope-of-service adjustment to the rate.

28 (k) An FQHC or RHC may elect to have pharmacy or dental  
29 services reimbursed on a fee-for-service basis, utilizing the current  
30 fee schedules established for those services. These costs shall be  
31 adjusted out of the FQHC's or RHC's clinic base rate as  
32 scope-of-service changes. An FQHC or RHC that reverses its  
33 election under this subdivision shall revert to its prior rate, subject  
34 to an increase to account for all Medicare Economic Index  
35 increases occurring during the intervening time period, and subject  
36 to any increase or decrease associated with applicable  
37 scope-of-service adjustments as provided in subdivision (e).

38 (l) FQHCs and RHCs may appeal a grievance or complaint  
39 concerning ratesetting, scope-of-service changes, and settlement  
40 of cost report audits, in the manner prescribed by Section 14171.

1 The rights and remedies provided under this subdivision are  
2 cumulative to the rights and remedies available under all other  
3 provisions of law of this state.

4 (m) The department shall, no later than March 30, 2008,  
5 promptly seek all necessary federal approvals in order to implement  
6 this section, including any amendments to the state plan. To the  
7 extent that any element or requirement of this section is not  
8 approved, the department shall submit a request to the federal  
9 Centers for Medicare and Medicaid Services for any waivers that  
10 would be necessary to implement this section.

11 (n) The department shall implement this section only to the  
12 extent that federal financial participation is obtained.

13 *SEC. 1.5. Section 14132.100 of the Welfare and Institutions*  
14 *Code is amended to read:*

15 14132.100. (a) The federally qualified health center services  
16 described in Section 1396d(a)(2)(C) of Title 42 of the United States  
17 Code are covered benefits.

18 (b) The rural health clinic services described in Section  
19 1396d(a)(2)(B) of Title 42 of the United States Code are covered  
20 benefits.

21 (c) Federally qualified health center services and rural health  
22 clinic services shall be reimbursed on a per-visit basis in  
23 accordance with the definition of “visit” set forth in subdivision  
24 (g).

25 (d) Effective October 1, 2004, and on each October~~1~~, *I*  
26 thereafter, until no longer required by federal law, federally  
27 qualified health center (FQHC) and rural health clinic (RHC)  
28 per-visit rates shall be increased by the Medicare Economic Index  
29 applicable to primary care services in the manner provided for in  
30 Section 1396a(bb)(3)(A) of Title 42 of the United States Code.  
31 Prior to January 1, 2004, FQHC and RHC per-visit rates shall be  
32 adjusted by the Medicare Economic Index in accordance with the  
33 methodology set forth in the state plan in effect on October 1,  
34 2001.

35 (e) (1) An FQHC or RHC may apply for an adjustment to its  
36 per-visit rate based on a change in the scope of services provided  
37 by the FQHC or RHC. Rate changes based on a change in the  
38 scope of services provided by an FQHC or RHC shall be evaluated  
39 in accordance with Medicare reasonable cost principles, as set

1 forth in Part 413 (commencing with Section 413.1) of Title 42 of  
2 the Code of Federal Regulations, or its successor.

3 (2) Subject to the conditions set forth in subparagraphs (A) to  
4 (D), inclusive, of paragraph (3), a change in scope of service means  
5 any of the following:

6 (A) The addition of a new FQHC or RHC service that is not  
7 incorporated in the baseline prospective payment system (PPS)  
8 rate, or a deletion of an FQHC or RHC service that is incorporated  
9 in the baseline PPS rate.

10 (B) A change in service due to amended regulatory requirements  
11 or rules.

12 (C) A change in service resulting from relocating or remodeling  
13 an FQHC or RHC.

14 (D) A change in types of services due to a change in applicable  
15 technology and medical practice utilized by the center or clinic.

16 (E) An increase in service intensity attributable to changes in  
17 the types of patients served, including, but not limited to,  
18 populations with HIV or AIDS, or other chronic diseases, or  
19 homeless, elderly, migrant, or other special populations.

20 (F) Any changes in any of the services described in subdivision  
21 (a) or (b), or in the provider mix of an FQHC or RHC or one of  
22 its sites.

23 (G) Changes in operating costs attributable to capital  
24 expenditures associated with a modification of the scope of any  
25 of the services described in subdivision (a) or (b), including new  
26 or expanded service facilities, regulatory compliance, or changes  
27 in technology or medical practices at the center or clinic.

28 (H) Indirect medical education adjustments and a direct graduate  
29 medical education payment that reflects the costs of providing  
30 teaching services to interns and residents.

31 (I) Any changes in the scope of a project approved by the federal  
32 Health Resources and ~~Service~~ *Services* Administration (HRSA).

33 (3) No change in costs shall, in and of itself, be considered a  
34 scope-of-service change unless all of the following apply:

35 (A) The increase or decrease in cost is attributable to an increase  
36 or decrease in the scope of services defined in subdivisions (a) and  
37 (b), as applicable.

38 (B) The cost is allowable under Medicare reasonable cost  
39 principles set forth in Part 413 (commencing with Section 413) of

1 Subchapter B of Chapter 4 of Title 42 of the Code of Federal  
2 Regulations, or its successor.

3 (C) The change in the scope of services is a change in the type,  
4 intensity, duration, or amount of services, or any combination  
5 thereof.

6 (D) The net change in the FQHC's or RHC's rate equals or  
7 exceeds 1.75 percent for the affected FQHC or RHC site. For  
8 FQHCs and RHCs that filed consolidated cost reports for multiple  
9 sites to establish the initial prospective payment reimbursement  
10 rate, the 1.75-percent threshold shall be applied to the average  
11 per-visit rate of all sites for the purposes of calculating the cost  
12 associated with a scope-of-service change. "Net change" means  
13 the per-visit rate change attributable to the cumulative effect of all  
14 increases and decreases for a particular fiscal year.

15 (4) An FQHC or RHC may submit requests for scope-of-service  
16 changes once per fiscal year, only within 90 days following the  
17 beginning of the FQHC's or RHC's fiscal year. Any approved  
18 increase or decrease in the provider's rate shall be retroactive to  
19 the beginning of the FQHC's or RHC's fiscal year in which the  
20 request is submitted.

21 (5) An FQHC or RHC shall submit a scope-of-service rate  
22 change request within 90 days ~~of~~ *after* the beginning of any FQHC  
23 or RHC fiscal year occurring after the effective date of this section,  
24 if, during the FQHC's or RHC's prior fiscal year, the FQHC or  
25 RHC experienced a decrease in the scope of services provided that  
26 the FQHC or RHC either knew or should have known would have  
27 resulted in a significantly lower per-visit rate. If an FQHC or RHC  
28 discontinues providing onsite pharmacy or dental services, it shall  
29 submit a scope-of-service rate change request within 90 days ~~of~~  
30 *after* the beginning of the following fiscal year. The rate change  
31 shall be effective as provided for in paragraph (4). As used in this  
32 paragraph, "significantly lower" means an average per-visit rate  
33 decrease in excess of 2.5 percent.

34 (6) (A) *The department shall conduct an initial review of a*  
35 *scope-of-service rate change request within 30 days after*  
36 *submission by an FQHC or RHC.*

37 (B) *If the department determines that additional information is*  
38 *necessary to finalize a new rate, the department shall notify the*  
39 *FQHC or RHC, no later than the 31st day after submission. The*  
40 *notification shall state the reason or reasons the submitted*

1 *information is insufficient and shall request submission of*  
2 *supplemental information from the FQHC or RHC.*

3 *(C) Within one year after receiving a submission that it*  
4 *determines to be complete, the department shall finalize the*  
5 *FQHC's or RHC's rate and shall update the provider master file*  
6 *within 10 business days.*

7 ~~(6)~~

8 (7) Notwithstanding paragraph (4), if the approved  
9 scope-of-service change or changes were initially implemented  
10 on or after the first day of an FQHC's or RHC's fiscal year ending  
11 in calendar year 2001, but before the adoption and issuance of  
12 written instructions for applying for a scope-of-service change,  
13 the adjusted reimbursement rate for that scope-of-service change  
14 shall be made retroactive to the date the scope-of-service change  
15 was initially implemented. Scope-of-service changes under this  
16 paragraph shall be required to be submitted within the later of 150  
17 days after the adoption and issuance of the written instructions by  
18 the department, or 150 days after the end of the FQHC's or RHC's  
19 fiscal year ending in 2003.

20 ~~(7)~~

21 (8) All references in this subdivision to "fiscal year" shall be  
22 construed to be references to the fiscal year of the individual FQHC  
23 or RHC, as the case may be.

24 (f) (1) An FQHC or RHC may request a supplemental payment  
25 if extraordinary circumstances beyond the control of the FQHC  
26 or RHC occur after December 31, 2001, and PPS payments are  
27 insufficient due to these extraordinary circumstances. Supplemental  
28 payments arising from extraordinary circumstances under this  
29 subdivision shall be solely and exclusively within the discretion  
30 of the department and shall not be subject to subdivision ~~(f)~~ (l).  
31 These supplemental payments shall be determined separately from  
32 the scope-of-service adjustments described in subdivision (e).  
33 Extraordinary circumstances include, but are not limited to, acts  
34 of nature, changes in applicable requirements in the Health and  
35 Safety Code, changes in applicable licensure requirements, and  
36 changes in applicable rules or regulations. Mere inflation of costs  
37 alone, absent extraordinary circumstances, shall not be grounds  
38 for supplemental payment. If an FQHC's or RHC's PPS rate is  
39 sufficient to cover its overall costs, including those associated with

1 the extraordinary circumstances, then a supplemental payment is  
2 not warranted.

3 (2) The department shall accept requests for supplemental  
4 payment at any time throughout the prospective payment rate year.

5 (3) Requests for supplemental payments shall be submitted in  
6 writing to the department and shall set forth the reasons for the  
7 request. Each request shall be accompanied by sufficient  
8 documentation to enable the department to act upon the request.  
9 Documentation shall include the data necessary to demonstrate  
10 that the circumstances for which supplemental payment is requested  
11 meet the requirements set forth in this section. Documentation  
12 shall include all of the following:

13 (A) A presentation of data to demonstrate reasons for the  
14 FQHC's or RHC's request for a supplemental payment.

15 (B) Documentation showing the cost implications. The cost  
16 impact shall be material and significant, two hundred thousand  
17 dollars (\$200,000) or 1 percent of a facility's total costs, whichever  
18 is less.

19 (4) A request shall be submitted for each affected year.

20 (5) Amounts granted for supplemental payment requests shall  
21 be paid as lump-sum amounts for those years and not as revised  
22 PPS rates, and shall be repaid by the FQHC or RHC to the extent  
23 that it is not expended for the specified purposes.

24 (6) The department shall notify the provider of the department's  
25 discretionary decision in writing.

26 (g) (1) An FQHC or RHC "visit" means a face-to-face  
27 encounter between an FQHC or RHC patient and a physician,  
28 physician assistant, nurse practitioner, certified nurse-midwife,  
29 clinical psychologist, licensed clinical social worker, or a visiting  
30 nurse. For purposes of this section, "physician" shall be interpreted  
31 in a manner consistent with the *federal* Centers for Medicare and  
32 Medicaid Services' Medicare Rural Health Clinic and Federally  
33 Qualified Health Center Manual (Publication 27), or its successor,  
34 only to the extent that it defines the professionals whose services  
35 are reimbursable on a per-visit basis and not as to the types of  
36 services that these professionals may render during these visits  
37 and shall include a ~~physician and surgeon~~, *medical doctor*,  
38 *osteopath*, podiatrist, dentist, optometrist, and chiropractor. A visit  
39 shall also include a face-to-face encounter between an FQHC or  
40 RHC patient and a comprehensive perinatal ~~services~~ practitioner,

1 as defined in Section ~~51179.1~~ 51179.7 of Title 22 of the California  
2 Code of Regulations, providing comprehensive perinatal services,  
3 a four-hour day of attendance at an adult day health care center,  
4 and any other provider identified in the state plan's definition of  
5 an FQHC or RHC visit.

6 (2) (A) A visit shall also include a face-to-face encounter  
7 between an FQHC or RHC patient and a dental ~~hygienist or~~  
8 *hygienist*, a dental hygienist in alternative ~~practice~~ *practice*, or a  
9 *marriage and family therapist*.

10 (B) Notwithstanding subdivision (e), an FQHC or RHC that  
11 currently includes the cost of the services of a dental hygienist in  
12 alternative ~~practice~~ *practice*, or a *marriage and family therapist*  
13 for the purposes of establishing its FQHC or RHC rate shall apply  
14 for an adjustment to its per-visit rate, and, after the rate adjustment  
15 has been approved by the department, shall bill these services as  
16 a separate visit. However, multiple encounters with dental  
17 professionals *or marriage and family therapists* that take place on  
18 the same day shall constitute a single visit. The department shall  
19 develop the appropriate forms to determine which FQHC's or ~~RHC~~  
20 *RHC's* rates shall be adjusted and to facilitate the calculation of  
21 the adjusted rates. An FQHC's or RHC's application for, or the  
22 department's approval of, a rate adjustment pursuant to this  
23 subparagraph shall not constitute a change in scope of service  
24 within the meaning of subdivision (e). An FQHC or RHC that  
25 applies for an adjustment to its rate pursuant to this subparagraph  
26 may continue to bill for all other FQHC or RHC visits at its existing  
27 per-visit rate, subject to reconciliation, until the rate adjustment  
28 for visits between an FQHC or RHC patient and a dental ~~hygienist~~  
29 *or hygienist*, a dental hygienist in alternative ~~practice~~ *practice*, or  
30 *a marriage and family therapist* has been approved. Any approved  
31 increase or decrease in the provider's rate shall be made within  
32 six months after the date of receipt of the department's rate  
33 adjustment forms pursuant to this subparagraph and shall be  
34 retroactive to the beginning of the fiscal year in which the FQHC  
35 or RHC submits the request, but in no case shall the effective date  
36 be earlier than January 1, 2008.

37 (C) An FQHC or RHC that does not provide dental ~~hygienist~~  
38 *or hygienist*, dental hygienist in alternative ~~practice~~ *practice*, or  
39 *marriage and family therapist* services, and later elects to add these

1 services, shall process the addition of these services as a change  
2 in scope of service pursuant to subdivision (e).

3 (h) If FQHC or RHC services are partially reimbursed by a  
4 third-party payer, such as a managed care entity (as defined in  
5 Section 1396u-2(a)(1)(B) of Title 42 of the United States Code),  
6 the Medicare ~~Program~~, *program*, or the Child Health and Disability  
7 Prevention (CHDP) program, the department shall reimburse an  
8 FQHC or RHC for the difference between its per-visit PPS rate  
9 and receipts from other plans or programs on a contract-by-contract  
10 basis and not in the aggregate, and may not include managed care  
11 financial incentive payments that are required by federal law to  
12 be excluded from the calculation.

13 (i) (1) An entity that first qualifies as an FQHC or RHC in the  
14 year 2001 or later, a newly licensed facility at a new location added  
15 to an existing FQHC or RHC, and any entity that is an existing  
16 FQHC or RHC that is relocated to a new site shall each have its  
17 reimbursement rate established in accordance with one of the  
18 following methods, as selected by the FQHC or RHC:

19 (A) The rate may be calculated on a per-visit basis in an amount  
20 that is equal to the average of the per-visit rates of three comparable  
21 FQHCs or RHCs located in the same or adjacent area with a similar  
22 caseload.

23 (B) In the absence of three comparable FQHCs or RHCs with  
24 a similar caseload, the rate may be calculated on a per-visit basis  
25 in an amount that is equal to the average of the per-visit rates of  
26 three comparable FQHCs or RHCs located in the same or an  
27 adjacent service area, or in a reasonably similar geographic area  
28 with respect to relevant social, health care, and economic  
29 characteristics.

30 (C) At a new entity's one-time election, the department shall  
31 establish a reimbursement rate, calculated on a per-visit basis, that  
32 is equal to 100 percent of the projected allowable costs to the  
33 FQHC or RHC of furnishing FQHC or RHC services during the  
34 first 12 months of operation as an FQHC or RHC. After the first  
35 12-month period, the projected per-visit rate shall be increased by  
36 the Medicare Economic Index (*MEI*) then in effect. The projected  
37 allowable costs for the first 12 months shall be cost settled and the  
38 prospective payment reimbursement rate shall be adjusted based  
39 on actual and allowable cost per visit. *The department shall finalize*  
40 *a new rate within one year after the submission of the actual cost*



1 *report from the first full 12 months of operation and shall update*  
2 *the department provider master file within 10 business days after*  
3 *finalizing the rate.*

4 (D) The department may adopt any further and additional  
5 methods of setting reimbursement rates for newly qualified FQHCs  
6 or RHCs as are consistent with Section 1396a(bb)(4) of Title 42  
7 of the United States Code.

8 (2) (A) In order for an FQHC or RHC to establish the  
9 comparability of its caseload for purposes of subparagraph (A) or  
10 ~~(B) of paragraph (1); caseload~~, the department shall require that  
11 the FQHC or RHC submit its most recent annual utilization report  
12 as submitted to the Office of Statewide Health Planning and  
13 Development, unless the FQHC or RHC was not required to file  
14 an annual utilization report. FQHCs or RHCs that have experienced  
15 changes in their services or caseload subsequent to the filing of  
16 the annual utilization report may submit to the department a  
17 completed report in the format applicable to the prior calendar  
18 year. FQHCs or RHCs that have not previously submitted an annual  
19 utilization report shall submit to the department a completed report  
20 in the format applicable to the prior calendar year. The FQHC or  
21 RHC shall not be required to submit the annual utilization report  
22 for the comparable FQHCs or RHCs to the department, but shall  
23 be required to identify the comparable FQHCs or RHCs. *This*  
24 *paragraph shall apply only to a facility that selects the*  
25 *comparability approach described in subparagraph (A) or (B) of*  
26 *paragraph (1).*

27 (B) *The department shall conduct an initial review of the three*  
28 *FQHCs or RHCs for the purpose of determining comparability*  
29 *within 30 days after submission by the new entity. If the department*  
30 *determines one or more of the submitted centers or clinics do not*  
31 *meet the comparability threshold, the department shall notify the*  
32 *new entity no later than the 31st day after submission.*

33 (C) *The notification shall state the reason or reasons for the*  
34 *finding of noncomparability and shall request a supplemental*  
35 *submission from the new entity. The request shall clearly state*  
36 *whether the new entity shall submit data from one, two, or three*  
37 *FQHCs or RHCs to meet the comparability threshold. Once the*  
38 *new entity submits its supplemental information, the initial review*  
39 *process described in subparagraph (B) shall apply.*

1 (D) *Within one year after receiving a submission determined*  
2 *by the department to be comparable, the department shall finalize*  
3 *the new entity's rate and shall update the provider master file*  
4 *within 10 business days.*

5 (3) The rate for any newly qualified entity set forth under this  
6 subdivision shall be effective retroactively to the later of the date  
7 that the entity was first qualified by the applicable federal agency  
8 as an FQHC or RHC, the date a new facility at a new location was  
9 added to an existing FQHC or RHC, or the date on which an  
10 existing FQHC or RHC was relocated to a new site. The FQHC  
11 or RHC shall be permitted to continue billing for Medi-Cal covered  
12 benefits on a fee-for-service basis *under its existing provider*  
13 *number*, until it is informed of its ~~enrollment as an FQHC or RHC,~~  
14 *RHC enrollment approval*, and the department shall reconcile the  
15 difference between the fee-for-service payments and the FQHC's  
16 or RHC's prospective payment rate at that time.

17 (j) Visits occurring at an intermittent clinic site, as defined in  
18 subdivision (h) of Section 1206 of the Health and Safety Code, of  
19 an existing FQHC or RHC, or in a mobile unit as defined by  
20 paragraph (2) of subdivision (b) of Section 1765.105 of the Health  
21 and Safety Code, shall be billed by and reimbursed at the same  
22 rate as the FQHC or RHC establishing the intermittent clinic site  
23 or the mobile unit, subject to the right of the FQHC or RHC to  
24 request a scope-of-service adjustment to the rate.

25 (k) An FQHC or RHC may elect to have pharmacy or dental  
26 services reimbursed on a fee-for-service basis, utilizing the current  
27 fee schedules established for those services. These costs shall be  
28 adjusted out of the FQHC's or RHC's clinic base rate as  
29 scope-of-service changes. An FQHC or RHC that reverses its  
30 election under this subdivision shall revert to its prior rate, subject  
31 to an increase to account for all ~~MEI~~ *Medicare Economic Index*  
32 increases occurring during the intervening time period, and subject  
33 to any increase or decrease associated with applicable  
34 ~~scope-of-services~~ *scope-of-service* adjustments as provided in  
35 subdivision (e).

36 ~~(l)~~

37 (l) FQHCs and RHCs may appeal a grievance or complaint  
38 concerning ratesetting, scope-of-service changes, and settlement  
39 of cost report audits, in the manner prescribed by Section 14171.  
40 The rights and remedies provided under this subdivision are

1 cumulative to the rights and remedies available under all other  
2 provisions of law of this state.

3 (m) The department shall, ~~by~~ no later than March 30, 2008,  
4 promptly seek all necessary federal approvals in order to implement  
5 this section, including any amendments to the state plan. To the  
6 extent that any element or requirement of this section is not  
7 approved, the department shall submit a request to the federal  
8 Centers for Medicare and Medicaid Services for any waivers that  
9 would be necessary to implement this section.

10 (n) The department shall implement this section only to the  
11 extent that federal financial participation is obtained.

12 (o) *The department shall correct erroneous payments at least*  
13 *quarterly to reprocess past claims and ensure all claims are*  
14 *reimbursed at the finalized new rate determined pursuant to either*  
15 *subdivision (e) or (i).*

16 *SEC. 2. Section 1.5 of this bill incorporates amendments to*  
17 *Section 14132.100 of the Welfare and Institutions Code proposed*  
18 *by both this bill and Senate Bill 610. It shall only become operative*  
19 *if (1) both bills are enacted and become effective on or before*  
20 *January 1, 2016, (2) each bill amends Section 14132.100 of the*  
21 *Welfare and Institutions Code, and (3) this bill is enacted after*  
22 *Senate Bill 610, in which case Section 1 of this bill shall not*  
23 *become operative.*